30 Prospect Street
Midland Park, NJ 07432

Dental History and Insurance Update

PATIENT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.		Today's Date:	
First Name:		Last Name:	
Birth Date:		SSN:	
Address:	City:	State:	Zip:
Home #:	Cell #:	Email:	

DENTAL HEALTH HISTORY
(CONFIDENTIAL)

MEDICAL HISTORY

Physician's Name: Date of last visit:

Have you had any serious illnesses or operations in the past year? If yes, please describe:

Have you ever taken Osteoporosis (low bone density) medications/bisphosphonates in the last year? ☐ YES ☐ NO

Have you been told by your physician that you need to premedicate before a dental procedure? If yes, please explain:

WOMEN: Are you pregnant? ☐ YES ☐ NO ∗ Nursing: ☐ YES ☐ NO ∗ Taking birth control pills: ☐ YES ☐ NO

Check( ) if you have or have had any of the following:

☐ AIDS	☐ Circulatory Problems	☐ Respiratory Disease	☐ Tonsillitis	☐ Tuberculosis
☐ Arthritis,Rheumatism	☐ Cough,Persistent	☐ Hepatitis	☐ Scarlet Fever	☐ Chemotherapy
☐ Artificial Heart Valves	☐ Cough up Blood	☐ High Blood Pressure	☐ Shortness of Breath	☐ Ulcer
☐CortisoneTreatments	☐ Anemia	☐ Stroke	☐ Diabetes	☐ Heart Problems
☐ Skin Rash	☐ Hemophilia	☐ Rheumatic Fever	☐ Artificial Joint	☐Kidney Disease
☐ Asthma	☐ Dialysis	☐ Jaw Pain	☐ Back Problem	
☐ Swelling of Feet or Ankle	☐ HIV Positive	☐ Epilepsy	☐ Thyroid Problems	
☐ Blood Disease	☐ Fainting	☐ Liver Disease	☐ Blood Transfusion	
☐Tobacco Habit	☐ Glaucoma	☐ Nervous Problems	☐ Psychiatric Care	
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Radiation Treatment	

☐ Chemical Dependency Describe:___________________________

MEDICATION

List medications you are currently taking:

____

ALLERGIES

☐ Aspirin ☐ Penicillin ☐Local Anesthetic
☐ Barbiturates ☐ Sulfa ☐ Codeine
☐ Latex ☐ Other

Pharmacy Name: ____ Phone: _______________________________________

____ __________________________
Patient Signature Date

____ __________________________
Doctor's Signature Date

INSURANCE INFORMATION

If your Dental Insurance changed, please update the information below.

Person Responsible for Account:

Relation to Patient: Birthdate SSN:

Address (if different from patient's) Phone:

City: State: Zip:

Person Responsible Employed by: Occupation:

Business Address: Business Phone:

Insurance Company: Subscriber ID: Group #:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with ___________________________________ and assign directly to Ohana Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

____

Responsible Party Signature Relationship: Date:

____

Doctor's Signature Date:

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. When our office books your appointment, we are setting aside a dedicated chair and time slot just for you, time is reserved, your materials are ordered and we make special arrangements to be ready for your visit. We only ask that if you must reschedule your appointment, that you please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of **$50 per hour** for giving less than 24 hours notice or not showing up to your appointment.

***Repeated cancellations or missed appointments will result in loss of future appointment privileges and appointments will only be made for same day treatment.**

Patient Name: ____ Date: _______________

Patient Signature: ____

Doctor's Signature: ____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that upon my request, I will receive a copy of the practice's *Notice of Privacy Practices*. I further acknowledge my understanding and agreement to the standards set forth in the notice. I understand the practice will not use my Private Health Information for purposes other than those specifically described in the notice. Additionally, I understand that my Private Health Information may be used at the discretion of the dentist, laboratories, pathologists or other healthcare professionals as necessary to render appropriate diagnosis and/or treatment.

Patient Name: ____________________________________ Patient Signature ______________________________

Doctor's Signature: _______________________________ Date: _______________________________________